**Workers' Compensation Health Care**

**Ad Hoc Quality Improvement Task Force**
**September 19, 2000**
**Minutes**

Participants included representatives from provider organizations (California Medical Association, California Association of Neurosurgeons, California Orthopedic Association, California Association of Occupational Health Nurses, California Association of Physicians' Assistants), and health care organizations (Kaiser Permanente, Sutter Health, Concentra, US Healthworks, CompPartners, Priority CompNet, and Sierra Health).

Background: At the first meeting of the ad hoc Quality Improvement Task Force, participants agreed that the identification of standardized performance measures in workers' compensation health care would be useful for (a) benchmarking for consumers and purchasers, and (b) internal quality improvement efforts by health care organizations. The group felt that reaching consensus on standardized measures related to care for low back pain and cumulative trauma of the upper extremities, and on a standardized patient satisfaction questionnaire, would be a good first step. The purpose of the September 19 meeting was to discuss specific proposed measures, and to begin discussion of possible implementation mechanisms.

Several years ago, the Association for the Accreditation of HealthCare/Utilization Review Accreditation Commission (AAHC/URAC) received funding from the Robert Wood Johnson Foundation to develop and pilot test a set of performance measures – including a patient satisfaction survey - for workers' compensation medical care. The AAHC/URAC project involved a national advisory committee including representatives from managed care organizations, insurers, employers, labor, and providers. It was agreed that the group would review the measures proposed by AAHC/URAC, select a relevant subset of the AAHC measures, and revise or add to them as the group felt appropriate.

**Administrative Measures:** Administrative data has been used to generate information on medical and disability costs, length of disability payments, and utilization of medical services (type, number, location). Two key characteristics of administrative measures were identified:
(1) collection of the data should be feasible, and
(2) the information provided by the measures should have utility for payors/consumers and/or internal quality improvement efforts – i.e. should identify actionable areas for improvement.
There was some concern about the effects of focusing on things that are feasible to measure (looking only where the light is shining).

*Where should the data come from?* Administrative data is typically available from a variety of sources, including insurers, health care organizations, vendor organizations (e.g. bill review), and employers. One question is whether an initial set of workers' compensation medical care performance measures should require data from multiple sources, or rely solely on data available

from one source. Using multiple data sources requires cooperation among different data providers and linkage of different data sets. There was agreement (no doubt determined by the make-up of participants) that the initial measure set should rely on data that is largely available from health care organizations. Although this would limit availability of data related to disability payments, the group agreed that the challenges associated with obtaining and linking data from payors should be deferred.

There are substantial differences in the nature of data available from different health care organizations. Almost all can generate data on diagnoses, utilization of health care services, and medical costs. Data on return-to-work is highly variable, depending largely on the structure of case management services within each organization.

*What do we want to know?*

Low Back Pain: Participants generated a long list of items of interest related to patterns of care for low back pain within their own organizations. Discussion identified several that could not be studied without chart review, and others for which differences in the structure of health care organizations preclude comparability. A shorter list of priority items was determined:

a. Provider access:
   - # of provider visits in first 30 days
   - time from Date of Injury to first visit
   - time from first visit to first re-check

b. diagnostic testing
   - x-rays in 1st 60 days
   - MRIs in 1st 60 days
   - CT in 1st 60 days

c. Manipulation
   - visits in 1st 60 days

d. PT
   - yes/no
   - time to referral
   - # visits 1st 60 days
   - active vs. passive PT codes

e. Surgery
   - % case w/ surgery

f. RTW
   - days to release to RTW
   - release with or without restrictions

g. Medication
   -# prescriptions/patient
   - % with opiates

Cumulative Trauma Disorders: A similar discussion ensued with regard to Cumulative Trauma Disorders-Upper Extremity (CTDUEs). There was no consensus as to whether all CTDUEs should be included, or the focus should be on carpal tunnel syndrome (CTS) alone; concerns were raised regarding the uniformity of diagnosis of CTS, and how that might impact measures focused only on CTS. Also, questions about the ability to differentiate between traumatic and cumulative injury (e.g. for diagnoses such as sprain/strain) were raised. The short list of items of interest included:

a. NCV/EMG (% of patients who receive)

b. Injections

c. Medication

d. Surgery

Methodological issues: A number of methodological concerns were raised, which will require further discussion before implementation of standardized measures can be achieved:

- can systems differentiate between patients discharged vs. patient referred "out of network"?
- using health care organization data, how can we deal with 30 day control, particularly for items where most appropriate measurement after 30 days may mean unknown loss to f/u (e.g. probably doesn't make sense to look at surgery in 1st 30 days, since rare)
- availability of data – e.g. specific meds prescribed
- information may depend on organization's networks (e.g. chiropractors in or out)
- lack of RTW information
- definitional issues (how to define LBP, what to include/exclude, CTS vs. all CTUEDs)
- severity adjustment
- case-mix adjustment (demographic, occupation, employer factors)

**Patient Survey:** The AAHC/URAC draft patient satisfaction measure was reviewed, with numerous comments about the wording of specific questions; these comments have been summarized and forwarded to URAC.

Preliminary discussion about implementation of surveys of injured workers included:
- mode: telephone is more expensive than mail, but has a better response rate
- sampling: should medical-only cases be included? should a certain $ amount or duration of care trigger inclusion?
- data requirements for sampling (DOI, name, address, date of birth, gender, phone #, ICD-9 diagnosis)
- costs ($25-40 mail, $60-$100 phone, per completed questionnaire depending on the vendor selected, total number of interviews and protocols used to boost response rate). We *estimate* that we would need 200 completed surveys per group; each organization could determine whether they wanted to evaluate patient perceptions for the organization as a whole (200 survey responses) or for individual clinics within the organization (200 per clinic).
- administration: use of a single vendor to administer the survey and analyze the results would both be cost-effective and ensure uniform administration. It was proposed that a consortium of organizations (such as California Cooperative HEDIS Reporting Initiative) could contract with a single vendor, or each organization could contract with the same vendor.
- reporting of results: each organization would receive aggregate results for the whole group, and results for the individual organization.

The costs of a survey raised significant concerns for many organizations. There was considerable doubt as to whether payors care about differences in performance or would pay any attention to the results in purchasing decisions; participants suggested it might be hard to "sell" the costs of a survey to management in the absence of any perceived marketing value. Questions were also raised about whether or not survey results would be specific enough to be "actionable" internally.

**Next steps:** Participants in the Quality Improvement Task Force are asked to review the attached materials, and complete the attached short survey about their interest in further pursuing the implementation of a pilot project to collect data for a small set of performance measures for low back pain and cumulative trauma of the upper extremities, and a standardized patient satisfaction survey. DWC will compile the results, and schedule another meeting to finalize a proposed measure set and discuss actual implementation issues.

## PLEASE COMPLETE THE ATTACHED SURVEY!
## Return by November 30 to:

## Quality of Care Task Force
## Fax: 415-703-4718

**Please return the survey (3 pages) below to DWC by December 1st**

Feasibility of proposed workers' compensation health care indicators

A. Administrative Measures: the following data elements would be required to determine the indicators proposed. Please indicate whether each data element is available – for each patient - in your organization's computerized database.

| DATA ELEMENT | CHECK IF AVAILABLE | COMMENTS |
|---|---|---|
| Patient Name | | |
| Patient Date of Birth | | |
| Patient Social Security Number | | |
| Patient Occupation | | |
| Patient Race/Ethnicity | | |
| Date of Injury | | |
| Diagnosis, Principal presenting | | |
| Diagnosis, Principal at end of follow-up | | |
| Diagnosis, Treatment-related (from HCFA 1500 | | |
| Date of first medical examination | | |
| CPT codes for services provided | | |
| Dates of individual CPT services | | |
| Place of service (ER, hospital, clinic, office, etc.) | | |
| Medication prescribed (specific drug code) | | |
| Provider specialty | | |

| | | |
|---|---|---|
| Patient referred to specialist (Y/N) | | |
| Type of specialist patient referred to | | |
| Patient released to return to work (Y/N) | | |
| Released with or without work restrictions? | | |
| Date released to RTW | | |
| Date of Actual Return to Work | | |
| Employment Status 90 days after release to RTW | | |
| Patient determined to be P&S | | |
| Date discharged from care | | |
| Health Care Organization FEIN | | |
| Employer ID (FEIN) | | |
| Employer Name | | |
| Payor name | | |
| Total medical charges | | |
| Total medical paid to health care organization | | |

Your Name _____

Organization _____

Phone _____ E-Mail _____

**FAX COMPLETED FORM TO: Quality of Care Task Force**
**415.703.4718**

B. Patient Survey:

| | YES | NO |
|---|---|---|
| a. My organization would be interested in participating in a standardized patient satisfaction survey. | ____ | ____ |
| b. My organization would be willing to pay $25 - $40 per respondent (minimum 200 per organizations) for a mailed survey. | ____ | ____ |
| c. My organization would be willing to pay $60 -$70 per respondent (minimum 200 per organizations) for a telephone survey. | ____ | ____ |
| d. My organization could provide the following information, for sampling: | | |
| Patient Name | ____ | ____ |
| Patient Address | ____ | ____ |
| Patient Phone | ____ | ____ |
| Patient Date of Injury | ____ | ____ |
| Patient SSN | ____ | ____ |
| Patient ICD diagnosis | ____ | |

Your Name _____

Organization _____

Phone _____

E-Mail _____

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